DOCUMENT RESUME

ED 404 681 CS 509 430

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TITLE Building and Testing a Model To Disseminate AIDS Awareness Information: A Time Series Analysis.
PUB DATE Nov 95
NOTE 22p.; Paper presented at the Annual Meeting of the Speech Communication Association (81st, San Antonio, TX, November 18-21, 1995).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; *Diffusion (Communication); *Females; Higher Education; High Schools; *Hispanic Americans; Information Dissemination; Minority Groups; Models; Sex Education
IDENTIFIERS Chicanas; *Health Communication; Latinas; Safe Sex Practices; Sexually Transmitted Diseases; Time Series Analysis

ABSTRACT

Young Chicanas/Latinas have a high risk of contracting HIV. However, their risk could be significantly reduced if information about AIDS and HIV is properly disseminated. Although some efforts have attempted to study the relationship between young populations and HIV, few studies have been conducted to study the relationship between Chicanos/Chicanas and HIV contraction. Even fewer projects have examined the above relationship with respect to Chicana/Latina women. A study explored the relationship between HIV awareness information and young Chicana/Latina populations. The model tested was used as a part of a retreat and conference for young Chicanas/Latinas, at which two co-founders, nine mature women, and nine young women were presented. If the model is successful, then the data should show an increase of AIDS awareness information. Data were collected at 3 intervals: immediately before the workshop, immediately after the workshop, and 4 months after the workshop. The pattern of these data is geometric--subjects' knowledge showed a statistically significant increase immediately after the workshop and levels of knowledge were maintained 4 months after the conclusion of the workshop. An alternative model which focuses on the source, barriers that need to be overcome, and strategies that can be employed to assist in educating young, Chicana/Latina women on HIV and AIDS awareness is suggested. Given the proposed model, the gap between AIDS information and behavioral changes can be bridged. (Contains 11 references.) (Author/CR)

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ED 404 681

Building and Testing A Model to Disseminate AIDS Awareness Information: A Time Series Analysis

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Abstract

Young Chicanas/Latinas have a high risk of contracting HIV. However, their risk could be significantly reduced if information about AIDS and HIV is properly disseminated. Although some efforts have attempted to study the relationship between young populations and HIV, few studies have been conducted to study the relationship between Chicanos/Chicanas and HIV contraction. Even fewer projects have examined the above relationship with respect to Chicana/Latina women. This study explores the relationship between HIV awareness information and young Chicana/Latina populations.

The model tested in this paper was used as part of a retreat and conference for young Chicanas/Latinas. If the model is successful, then the data should show an increase of AIDS awareness information. Data was collected at three intervals: immediately before the workshop, immediately after the workshop, and four months after the workshop. The pattern of these data is geometric--subjects knowledge showed a statistically significant increase immediately after the workshop and these levels of knowledge were maintained four months after the conclusion of the workshop.

This paper concludes by suggesting an alternative model which focuses on the source, barriers that need to be overcome, and strategies that can be employed to assist in educating young Chicana/Latina women on HIV and AIDS awareness. Given the proposed model, the gap between AIDS information and behavioral changes can be bridged .

Building and Testing A Model to Disseminate AIDS

Awareness Information: A Time Series Analysis

As the Hispanic population increases in the United States, there is an ever increasing need to research this population in relation to AIDS. According to the U.S. Census Bureau (1994), Hispanics compose 22.8 million or 8.9% of the total population. Hispanics represents Mexicans (64.3%), Central and South Americans (13.4%), Puerto Ricans (10.6%), Cubans (4.7%), and other (7.0%) (U.S. Census Bureau, 1994). Acknowledging the proportion of the Hispanic population, the Center for Disease Control and Prevention (CDC) writes that of the reported AIDS cases for 1993--totaling 103,691--Hispanics constitute 15,681 or 15.12% of those cases which makes them the second highest minority group affected by AIDS (CDC, 1994, pp. 9-12). Quite clearly, there is a disproportionate effect of AIDS to the Hispanic population.

Although research is increasing on Hispanics and AIDS, research approaches have not taken into consideration factors that impede the dissemination of AIDS information and target groups are defined too broadly. In particular, studies (Borman, 1993; Hu, Keller, and Fleming, 1989; Schinke, Gordon, and Weston, 1990; and Yep, 1992) that have been conducted do not distinguish among the various sub-groups composing the term Hispanic. To the extent that Hispanic is utilized in the studies causes difficulties in correctly assessing the group(s) affected by AIDS. This is problematic due to proportion of ethnicity's composing Hispanics. Amaro (1988) writes "[t]he lack of specific Hispanic group identifiers in AIDS data is a serious drawback . . . " in the epidemology of AIDS patterns (p. 431).

In order to devise effective educational efforts for this population, there is a need to differentiate among the sub-groups, in addition to conducting studies specifically focusing on women and AIDS ". . . because Hispanic group[s] is not specified in the ethnicity identifier, it is not possible to accurately determine in which Hispanic groups women are at most risk for AIDS" (Amaro, 1988, p. 432). The focus of this paper is on increasing our--researchers, scholars, and

community organizers--knowledge of disseminating AIDS awareness and prevention information to Chicanas and Latinas.[1] There are two components of the paper: the presentation and empirical assessment of one educational model, and the suggestion of a model to increase AIDS education for this specific population.

Literature Review

Hu et al. (1989) conducted a study on a sample of 216 Hispanics, who were defined as anyone with Spanish surname or claimed origin from a Spanish speaking country. Each of the subjects volunteered to be interviewed concerning their media usage (i.e., television, radio, and newspapers). Television use was ranked the highest in receiving information about AIDS. Next, researchers determined where there was an increase in English, as the primary language, it correlated with a higher knowledge of AIDS information. Hu et al. concluded that Hispanics receive relatively low amounts of AIDS information. The authors suggestions for educating this population are: 1) the message must be expressed in a comprehensive manner--taking into consideration any language barriers, and 2) the way(s) in which information is disseminated needs to be adjusted to high illiteracy rates.

Yep (1992) analyzed multiple studies focusing on Hispanics in relation to a communication/ persuasion model (i.e., source, message, channel, receiver, and destination factors). His findings revealed that Hispanics prefer talking with friends and professionals about questions they have about AIDS. For the message to be effective it should not be directly translated from English to Spanish, and that HIV/AIDS materials need to be culturally, spiritually, and socially relevant to Hispanics. The most effective channel is through an AIDS hotline, electronic media, and/or interpersonal communication. As the receiver, Hispanics seem to be the least knowledgeable when compared to Whites, African-Americans, and Asians; and also, that the degree of acculturation affects their knowledge level. Finally, with respect to Hispanic males, strategies need to be developed to encourage them to use condoms--as they are least responsive to this issue.

Concurring that interpersonal communication is the most effective means of educating and preventing the spread of AIDS are Williams (1990) and Cline, Freeman, and Johnson (1990). In the former study, Williams used an artifact to examine the dialogue that takes place between partners regarding practicing safe sex. Williams concluded that persuasion strategies via interpersonal communication lead to the practicing of safe sex. Cline et al. (1990) focused on delineating the factors that explain those who discuss AIDS with their sexual partners. Utilizing a survey method that inquired about students' knowledge, attitudes, and behavior regarding AIDS and communicating about AIDS, the researchers conclude that women should be the primary audience for encouraging condom use.

Acknowledging the conclusions of Cline et al., this paper contends that the responsibility lies not only with women encouraging men to use condoms, but that strategies also need to be developed to encourage men to use condoms without being asked. First, ". . . HIV education must be not only for and by women, but men as well" writes the Panos Institute, ". . . because decisions about sexual behavior cannot be separated from the wider social and cultural influences" (1990, p. 91). The Institute concludes HIV is not only a medical issue but one of equity and "without radical change, women and particularly the most disadvantaged women in the poorest communities . . . will remain in 'triple jeopardy'" (p. 92).[2]

Contrasted with the above studies Amaro (1988) identified three major characteristics that impede AIDS prevention and are issues that need to be taken into consideration when discussing AIDS and Hispanic women. The first characteristic to be considered in developing preventative measures is the sociodemographic status of Hispanic women (i.e., age, educational attainment, economic factors, the level of acculturation, and any language barriers). Second, are the reproductive characteristics such as the types of contraception's used and the increasing numbers of teen mothers who are not educated on protecting themselves from pregnancy and sexually transmitted diseases. Finally, cultural and religious beliefs need to be taken into consideration such

as the practice of Catholicism (which Amaro contends varies among younger Hispanics), as well as other traditions based on Mexican culture.

Expanding on the need to consider social and cultural group contexts, Croteau, Nero, and Prosser (1993) provide an overview of three issues that affect HIV/AIDS prevention among women, gay and bisexual men, African-Americans, and Latinos.[3] The first issue that they discuss is the negative information that is perpetuated such as myths which stigmatize cultural groups (e.g., Latino men and machismo or Latina women being portrayed as baby machines). Croteau et al. argue that the communication of such myths is counter productive because first, they represent the subjects as not having control over their sexuality; and second, the myths are destructive. Counter to this and cited in Yep (1992), machismo is considered a cultural Hispanic value and "[m]achismo, a Hispanic gender role behavior, alludes to the assumed cultural expectation for men to be dominant in social relationships" (p. 408). The authors of this paper argue that the continued perpetuation of the myth of machismo is especially dangerous in light of the focus of this paper--on Chicana and Latina young women. To propagate machismo socializes and engenders young Chicanas and Latinas of their role in a relationship (that being submissive, powerless, and under the control of a Chicano or Latino male). Machismo must be discussed as a myth because to discuss it in any other terms (e.g., a Hispanic value) has Chicanas and Latinas accepting it as the norm, and failing to acknowledge, nor question, its damaging effects.

The second issue affecting prevention, according to Croteau et al., is that individuals in society hold group-specific misconceptions about HIV/AIDS which serve as barriers to effective prevention behavioral changes. Some of the misconceptions discussed are that HIV and AIDS is an attempt by the dominant culture of genocide; that the disease is exclusive to white gay males; and that misinformation about HIV transmission is proffered. Finally, Croteau et al. state that membership in two or more of the groups leads to difficulty in designing prevention related behavior due to multi-dimensional and/or stigmatization (e.g., women need to have information focused on both their gender and their race/ethnicity).

The recommendations by Croteau et al. for a culturally sensitive program are to include the targeted group members (i.e., gay men, African Americans, Latinos, and women) as full partners in developing programs. Next, peer leaders need to be involved in the process who can serve as advocates for prevention because among " . . . socially marginalized groups . . . traditional attempts to reach these groups may fail" (Croteau et al., p. 293). There is also the need to include culturally relevant content, media, and settings wherein specific language or vernacular would be appropriate to particular environments. The last recommendation offered is that group pride should be fostered which increases self-esteem.

Kalichman, Hunter, and Kelly (1992) examined high-risk behavior in relation to levels of knowledge about AIDS. They argue that several factors affect the epidemology patterns of AIDS among, in particular, ethnic minority women (i.e., minority adults report having lower levels of knowledge of HIV/AIDS; minority women perceive only gay men and drug users as being affected; certain social, cultural, and sex roles serve as barriers; and there are other socio-economic problems that are more pressing). They posit that high risk behavior (e.g., multiple sex partners, drug use, bi-sexual partners, previous contraction of a sexually transmitted disease) is equated with lower levels of AIDS knowledge, less personal sensitivity to risk, and less accurate estimations of personal risk. Kalichman et al. also examine differences between minority and non-minority women with respect to AIDS knowledge, perceptions, and experiences.

The findings revealed in the above study are several: first, women at high risk had greater concern for themselves and an acquaintance in developing AIDS; second, minority versus non-minority women report other socio-economic issues are of greater concern than contracting AIDS or any other disease. The second finding should not be considered a revelation but as testament to the socio-economic position of women of color and the problems they face in the dominant society. Third, minority women demonstrate having less accurate information about AIDS than non-minority women. Hence, non-minority women posses greater amounts of accurate AIDS information. In reaching this conclusion, what is not addressed in this study is if non-minority

women, in possessing greater amounts of information, changed their behavior (i.e., did possessing knowledge equate to practicing safe sex?). The last finding is that minority women were less likely to have recently (last six months) discussed AIDS.

Empirical Analysis

The Model

The model tested in this study was used by a Chicana/Latina mentoring program (i.e., CHICAS, Chicanas Involved in Community Action for Success) which is designed to promote higher education and increase awareness of AIDS.[4] At the onset of the mentoring program, participants attended a three day retreat and one day conference. The conference focused on various issues (e.g., high school and college requirements, goal setting, sexual harassment, and an AIDS workshop). For the AIDS workshop, a facilitator conducted a two hour session addressing several areas.[5] The first area was designed to provide an overview of STD's and AIDS and the transmission of the diseases. Second, preventative methods of AIDS were addressed through discussions and exercises (e.g., how to practice safe sex and acquainting the participants with various safe sex materials and referral information). Finally, participants were broken up into small groups which were facilitated by the mujeres, wherein the groups discussed hypothetical case studies.

Subjects

The workshop participants consisted of two co-founders, nine mujeres (ages 22-28), and nine chicas (ages 17-19).[6] Among the co-founders and mujeres, seven are working on or have completed their bachelor's degrees, two are working on their master's degree, one is enrolled as a Ph.D. candidate, and one is enrolled as a J.D. candidate. The education among the chicas consists of one in her last year of high school, two are completing a high school equivalency, two have high school diplomas, and four are in their first year of college.

Method

Questionnaires measuring participants' AIDS knowledge were distributed on three occasions: immediately before the workshop, immediately after the workshop, and four months after the workshop. The questionnaires asked a series of questions pertaining to the participants' knowledge of AIDS and safe sex behavior. Given that this paper has been designed to examine the relationship between providing AIDS information and knowledge of AIDS issues, data pertaining to safe sex behavior has been excluded. Additionally, given the sensitive nature of reporting safe sex behavior, a response bias could potentially contaminate the data. As such, behavioral outcomes are not reported. Six items were used to measure AIDS knowledge.

Results

As suggested above, participants' AIDS knowledge was measured on three occasions. The means for each of the items are presented below.

	Time 1*	**Time 2****	**Time 3*****
What is AIDS?	2.41 (.80)	2.88 (.33)	2.88 (.33)
What is HIV?	2.00 (.71)	2.59 (.62)	2.80 (.39)
How can you get AIDS?	2.41 (.71)	2.94 (.24)	2.82 (.24)
How can you prevent AIDS?	1.41 (.94)	2.65 (.49)	2.66 (.43)
What are risky behaviors?	2.29 (.58)	2.82 (.39)	2.59 (.51)
Who can get AIDS?	4.94 (.42)	5.59 (.51)	5.52 (.50)

* before the workshop

** immediately after the workshop

*** four months after the workshop

- standard deviations provided in parenthesis next to the means
- items 1-5 could potentially range from 0 to 3.00
- item 6 could potentially range from 0 to 6.00

If the workshop was successful in increasing AIDS knowledge to participants, then the data should show an increase in AIDS knowledge from Time 1 to Time 2 and that knowledge should remain unaffected at Time 3. As such, the following research question is offered: How does AIDS knowledge vary over time?

Given that data was collected at three points, the overall trend of the data could reveal linear, geometric, or quadratic patterns. For each of the six terms, contrasts testing the linear, geometric, and quadratic models were applied. The decomposed sum of squares for a linear (-1, 0, +1), geometric (-2, +1, +1), and quadratic (-1, +2, -1), were obtained. Only the two models with the highest sums of squares are presented.

Item 1 - What is AIDS?

Source	SS	df	F	*p*
linear	1.7	1	6.26	.05
geometric	2.41	1	8.33	.001

Item 2 - What is HIV?

Source	SS	df	F	*p*
linear	6.28	1	17.42	.05
geometric	8.82	1	36.73	.0001

Item 3 - How can you get AIDS?

Source	SS	df	F	*p*
linear	4.91	1	16.34	.05
geometric	5.45	1	27.12	.0001

Item 4 - How can you prevent AIDS?

Source	SS	df	F	*p*
linear	8.82	1	5.44	.02
geometric	10.32	1	8.25	.001

Item 5 - What are risky behaviors?

Source	SS	df	F	*p*
linear	2.04	1	3.62	.05
quadratic	2.98	1	7.51	.002

Item 6 - Who can get AIDS?

Source	SS	df	F	*p*
linear	2.38	1	5.44	.02
geometric	3.18	1	8.25	.001

Discussion of Results

These data suggest that the participants' knowledge showed an increase from Time 1 to Time 2 and that their knowledge was unaffected from Time 2 to Time 3. Although the linear contrast (-1, 0, +1) reveals significant findings in all cases (except for item 5), the geometric model (-2, +1, +1) suggests a better fit of the data. That is, the best fit for these data is that participants' AIDS knowledge increased from Time 1 to Time 2 and leveled off between Time 2 and Time 3. These data do present some useful findings in that they reveal that the CHICAS workshop had a significant effect on participants' knowledge.

Although this study does present some useful findings, it is not without limitations. First, the small sample size does present the possibility that differences found in the data were due to sampling error. However, given that this study looked at a very specific subgroup of a minority population, large sample sizes will not come easily. As such, these data should still be taken into consideration. Future research could use the findings to help build better AIDS information transmission models.

A second limitation of this study is in its ability to change behavioral patterns. Although the data presented here shows enhanced knowledge with respect to AIDS knowledge of participants, it does not address the more pressing issue of behavior change. Given the sensitive nature of this topic (response bias), future researchers will have difficulty providing accurate data of behavioral change. However, it is argued here, that knowledge of AIDS information is a pre-

requisite to behavior change. Hence, this study does provide at least a modicum of useful information to the establishment of a foundation for behavior change.

Designing Future Models

The current model, as purported by the authors of this paper, is based on a review of the literature and a modification of the CHICAS workshop (i.e., the discussion of the empirical analysis). The model is designed for the dissemination of AIDS prevention information, specifically to young Chicanas and Latinas. The explication of this model is vital to the extent that Amaro (1988) writes, ". . . communication among professionals working on the design of AIDS prevention programs and research in Hispanic communities is needed" (p. 439). Furthermore, that "an extensive literature review fail[s] to reveal the description of a single prevention education program dealing exclusively with the concerns of [Chicana/ Latina] women" (Croteau et al., 1993, p. 293).

The current model needs to focus on taking a pragmatic approach towards empowering Chicanas and Latinas and this can be achieved through several ways. The first of which is the establishing of mentoring programs that will serve as the vehicle to address who will be the sources of information, how specific barriers will be overcome, and what are the strategies pertinent to this specific population. By empowering these young women through mentoring programs, they can protect themselves effectively, change their sexual behavior, and feel that their actions are not being controlled or regulated by others (e.g., family, friends, boyfriends, or the dominant culture).

Sources

The current model suggests using a mentoring program as the vehicle for disseminating AIDS prevention information. When establishing a mentoring program, the purpose and the objectives of the program will depend on the needs of participants (e.g., some Chicanas and Latinas may need information pertaining to job skills, others may need child care skills, etc.). But

whatever the purpose, informing and disseminating AIDS information also should be a part of the objectives, in light of Chicana and Latina women being the least informed on this disease.

In using a mentoring program (which would be composed entirely of Chicanas and Latinas) several benefits are derived, one of which is that group pride is fostered (Croteau et al., 1993). By interacting with one another Chicanas and Latinas have a place to go to wherein there is a shared understanding of culture and ethnicity. A second benefit is that there is continuity among the participants due to the required commitment for participation in the program. Each participant (mentee) will also be assigned a mentor to work with, as well as having a variety of other mentors and peers to turn to for assistance and guidance. Mentors can also serve as facilitators or evaluators in regard to problems that the mentees may be experiencing or even in understanding (due to language barriers) how to employ safe sex practices.

Within the current model, there are two components: monthly workshops and one-on-one meetings. The monthly workshops assist Chicanas and Latinas in obtaining the AIDS prevention information that is vital for their lives. Workshops can be either demonstrative or informative but a combination would be optimal. For example, speakers (specifically women with HIV or AIDS) could be invited to speak with Chicanas and Latinas, an alternative to a health professional spokesperson, and asked to share their experiences in living with the disease. The Panos Institute (1990) writes, "[s]ome of the most powerful spokeswomen are proving to be women with HIV or AIDS. Their involvement dramatically increases the emotional impact of the information provided" (p. 75). This tactic may prove to be more effective in getting Chicanas and Latinas to change their behavioral patterns rather than having a health professional discuss the statistics and effects of AIDS. However, this is not to advocate that health professionals should not be invited to speak, but the pathos revealed in a personal story is undeniable. Aside from inviting speakers, the workshops can serve as a forum to update Chicanas and Latinas on new information about AIDS, as well as assist them in addressing problems and/or developing new strategies.

The second aspect of the mentoring program is to have one-on-one meetings. Each participant will be assigned a mentor to work with who will be able to provide individual attention through one-on-one meetings. The provision for individual attention in the mentor/mentee relationship is important in that it fosters trust, safety, and respect for one another. Through interpersonal communication mentees can feel comfortable asking questions they may have about HIV or AIDS; whereas, in other interpersonal settings/relationships they may not be asking these same questions due to feelings of embarrassment and uncomfortableness. Mentors, playing on their role as facilitators, and being more in a position to inquire about personal issues, they can ask mentees about their behavioral changes (e.g., are they practicing safe sex, if not, then why?). From this interaction, the information can be addressed within the workshops--without specifically acknowledging the mentee--to either alter future workshops, initiate discussions, or to develop other strategies.

Overcoming Barriers

The end goal of the proposed model is to inform Chicanas and Latinas on how to protect themselves and provide them with strategies for changing their behavior in relation to AIDS. However, in order to reach this point, other factors or barriers need to be taken into consideration in the context of the mentoring program. Because ". . . minority women ascribe higher levels of seriousness to a range of life problems faced by urban women as compared with their non-minority counterparts," (Kalichman et al., 1992, p. 731) and that AIDS is considered not as serious of a problem when there are other pressing issues (e.g., employment, child care, etc.) to be managed. Therefore, various barriers need to be taken into consideration in all aspects of disseminating AIDS information because of the conflicts that could arise. The barriers are explicated below.

- Educational Attainment: According to the U. S. Census Bureau (1994), the educational levels of Hispanics is well below non-Hispanics. Furthermore, younger versus older Hispanics are no more likely to have a bachelor's degree. And specifically, Mexicans are the least likely to

have a high school diploma or the equivalent. Therefore, the dissemination of AIDS information and the way in which it is discussed needs to be tailored to the education level of the focus group in order to be useful.

- Economic Factors: To the extent that Chicanas and Latinas may experience difficulty in finding a job and/or maintaining low paying jobs, this issue would take precedence over other social and health issues. Also, because economics is a concern it then bears on Chicana/Latinas access to health care and what is affordable; therefore, limiting medical accessibility. This problem is magnified in certain demographics of the country (e.g., California and the passing of Proposition 187 where immigrants are denied to any medical care with the exception of emergency medical situations). Furthermore, because their wages are not parallel with non-minority women, there is a power differential--class status. In turn, this could affect Chicanas and Latinas receptivity to AIDS information depending on who is the sender of the information.
- Level of Acculturation: This is dependent on one, how long Latinas have been in the United States and two, to what extent are cultural and ethnic traditions maintained in the participants' families. Depending on these factors, they affect how much Chicanas and Latinas have adapted and are receptive to the dominant culture. If Chicana/Latina women are acculturated, then their receptivity to receiving and discussing AIDS information is heightened; however, for Chicanas and Latinas who are not acculturated, and moreso assimilated into the dominant society, speaking about sex and AIDS can be an uncomfortable and almost taboo topic.
- Language Barriers: For Chicanas, the language may not be a problem, as for many it can be suggested that English is their first language. However, based on generational differences, some Latinas may speak Spanish as their first language, so that in discussing AIDS prevention it can be problematic depending on how the information is explained. Therefore, during workshops the language should be adapted and/or someone who is bi-lingual should be present. Also, the use of code-switching can facilitate the explanation of concepts (e.g.,

transmission, effects of AIDS, etc.). Taken together, these suggestions assist in the mentee's understanding and identification with the information.

- Cultural and Religious Beliefs: As previously discussed, the myth of machismo should be discussed so as to deconstruct both the term and its fallacies. To not discuss the myth, perpetuates it and leads young Chicanas and Latinas to accept a subordinate position in relationships. Other cultural beliefs such as the role of women in relationships and thoughts on sex (e.g., for pleasure versus procreation or on deciding whether or not to have sex) need to be discussed. This last issue can be difficult, especially in regard to AIDS information, because this could be the first time these women have discussed sex and AIDS.

  For most Chicanas and Latinas, Catholicism is the most widely accepted religion but its practice among younger people is questionable (Amaro, 1988). However, whether or not the religion is practiced, the values stemming from that religion are handed down to generations. Hence, participants need to be questioned in terms of the degree of their beliefs stemming from the church, in order to modify workshops. Based on their beliefs in Catholicism, or other organized religions, can affect their reception to AIDS information wherein sex is explicit which may very well run counter to what the participants have been taught.
- Patriarchy of the Family: Among most Chicana/o and Latina/o families, the father is the patriarch. In the absence of a father, most often a brother assumes that role. As such, the patriarch controls all decisions and actions of the family. This barrier can affect Chicanas and Latinas participation in a mentoring program as well as the patriarch's belief that issues of sex and AIDS should even be discussed. Therefore, this needs to be discussed in terms of individual Chicanas and Latinas, and how does this constrain or serve as barrier to them, personally.
- Perpetuation of Attitudes and Beliefs: Among Chicanas and Latinas attitudes and beliefs about sex, HIV/AIDS, safe sex, etc. may differ depending on their knowledge and their personal experience. Due to this the participant's attitudes need to be brought into the open and

discussed (e.g., what misconceptions are maintained). Furthermore, their beliefs about the issues stated need to talked about in a safe environment wherein they do not have to fear ridicule and also know that information that is shared is confidential. Only through discussing these things can a discussion about how to protect oneself proceed.

Strategies

Strategies that have been previously suggested are: being faithful to one partner, reducing and/or avoiding having multiple sexual partners, asking your partner about their sexual history, using condoms, and trying alternatives to sex (Berer, 1993). As discussed by Berer, these strategies are both valuable and limiting. The one strategy that is advocated most prominently is the use of condoms; however, specific strategies are not being discussed in terms of how to ask a partner to use a condom. In part, for this strategy to be used by Chicanas and Latinas they need to have the information and/or the skills concerning how to go about obtaining their partners' agreement.

If Chicanas and Latinas are unsuccessful in gaining compliance in condom use, then they need to be made aware of what to do in that or other situations. Also, within the workshops it is important to discuss the willingness to risk the loss of a partner and/or the relationship in preventing themselves from AIDS. If this strategy--condom use--is promoted, then cultural myths and perceptions also need to be considered. This is important because for Chicanas and Latinas to carry around condoms or have them readily available suggests they are promiscuous and are equated with the "bad woman" syndrome.[7] The ramification of this being that condoms may not be carried at all in order to prevent any connotations or labels being applied to the young women by their partners. They also need to be taught to re-think their ideas of sex and that there are other ways of obtaining sexual pleasure. That is, intercourse does not have to equate with having sex.

One final strategy that is vitally important and rarely mentioned is the need for communication. Assisting Chicanas and Latinas in establishing lines of communication with their mentors, their family and friends, and more importantly their sexual partners is necessary. In all of

the aforementioned relationships, young Chicanas and Latinas need to discuss their thoughts on sex and sexuality. In the context of the mentoring program and the workshops, discussions can be mediated about HIV/AIDS transmission; small group discussions of hypothetical situations can be addressed and specific strategies can be developed; also, role-playing realistic situations that the mentees feel they may encounter will assist them in dealing with the situation should it occur. Only through communication can workshops, strategies, reasons for not using condoms, practicing safe sex, and behavioral changes be addressed.

The implications stemming from this study is that the findings reveal one way to disseminate and increase AIDS prevention information among a specific group--Chicana and Latina women. The study addressed in this paper examined how utilizing a mentoring program facilitates and is successful in disseminating AIDS information to young Chicana/Latina women. Furthermore, based on the review of literature and modifying the model studied, suggestions are provided to develop future programs (i.e., consideration needs to be given to the types of sources, specific barriers need to be addressed, and strategies are delineated). Consequently, mentoring programs will not only facilitate the dissemination of AIDS information, but can foster and lead to behavioral changes.

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Endnotes

1 In the context of this paper, Chicanas refers to women of Mexican descent who are born in the United States; whereas, Latinas refers to women born outside of the U.S. and more specifically in Central American countries. All participants identify with one or both labels.

2 "Triple jeopardy" (normally distinguished as women of color facing the intersections of race, class, and gender) is different in this context--The Panos Institute refers to "triple jeopardy" as "the dangers women face as individuals, mothers, and careers in the face of the AIDS pandemic" (1990, preface).

3 In regard to women and Latinos, Croteau et al. do not appear to distinguish among the subjects composing either category.

4 Information on the CHICAS mentoring program can be obtained from one of the authors of the paper, Michelle A. Holling.

5 The facilitator for the workshop, at the time, had worked for several years with a non-profit organization that focused on the dissemination of AIDS awareness. She is also writing her master's thesis on developing AIDS strategies for African-American women prostitutes and intra-venous drug users.

6 In the program, mujeres [women] serve in the role of mentors and chicas [young girls] are protégés or mentees.

7 The dichotomy most often applied to Chicanas and Latinas is that of the "good and bad woman" syndrome. The dichotomy is paralleled to cultural symbols such as La Virgen de Guadalupe [the Virgin] and La Malinche, each of whom maintain virtuous and mother-like qualities or wild, whore-like qualities (respectively).